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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NANCY SUE SUMMERS, aka** **NANCY SUE SUMMERS-REYES** 15700 Belshire Avenue, Apt 10 Norwalk, California 90650 Registered Nurse License No. 548533 Respondent.	Case No. 2009-291 **A C C U S A T I O N**

Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

License History

2. On or about October 2, 1998, the Board issued Registered Nurse License Number 548533 ("license") to Nancy Sue Summers, also known as Nancy Sue Summers-Reyes ("Respondent"). The license expired on January 31, 2004, and has not been renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a

temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

8. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Arizona State Board of Nursing ("Arizona Board"). In the action entitled, *In the Matter of the Privilege to Practice Nursing Under the Nurse Licensure Compact in the State of Arizona Issued to: Nancy Sue Summers, aka Nancy Sue Summers-Reyes, Respondent, Nurse License No. RN0001176358, Commonwealth of Virginia*, effective April 2, 2008, pursuant to a Consent to Voluntary Surrender Multi-State Licensure Privilege in Arizona and Cease and Desist Order No. 0710030, Respondent voluntarily surrendered her privilege to practice nursing under her Multi-State License No. RN0001176358. A copy of the Arizona Board's Cease and Desist Order No. 0710030 is attached as **Exhibit A,** and is incorporated herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 548533 issued to Nancy Sue Summers, also known as Nancy Sue Summers-Reyes;

2. Ordering Nancy Sue Summers, also known as Nancy Sue Summers-Reyes, to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/15/09

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2008504512
30643218.wpd

Janet Napolitano
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
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AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF ARIZONA

COUNTY OF MARICOPA

I, Joey Ridenour, Executive Director for the Arizona State Board of Nursing, County of Maricopa, State of Arizona, do hereby certify that I am the officer having the legal custody for the records hereto attached in the office of the Arizona State Board of Nursing, County of Maricopa, State of Arizona, a public office of said State. The attached copies are true copies of the records on **NANCY SUE SUMMERS**. Personnel of the Arizona State Board of Nursing prepared the records during the ordinary course of business.

Witness my hand and the seal of the Arizona State Board of Nursing at 4747 N. 7th Street, Suite 200, Phoenix, Arizona, 85020, on October 21, 2008.

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Arizona State Board of Nursing

Date Printed: 10/21/2008 By: ANNE PARLIN, STAFF

NAME NANCY SUE SUMMERS

GENDER: F **ETHNICITY:** White - Not of Hispanic Origin

PLACE OF BIRTH CITY: MEDINA **STATE:** OH

HOME ADDRESS

10940 W MORTEN AVE

GLENDALE AZ 85307

County: Maricopa

Country:

HOME PHONE: N/A **PAGER:** N/A **CELL PHONE:** N/A

BUSINESS PHONE: N/A **FAX:** N/A

E-MAIL: mscnan04@aol.com

OTHER NAMES

NAMES USED	REASON	NAMES USED	REASON
NANCY NANCY SUMMERS-REYES	Former Name	NANCY SUE SUMMERS	

AZ LICENSE/CERTIFICATION INFORMATION:

License/Certificate Number:

License Type: TEMP RN

Original Date:

Expiration/Next Renewal Date:

Last Issued Date:

Original State of Licensure/Certification:

AZ LICENSE STATUS HISTORY

STATUS	FROM	TO	LAST MODIFIED BY:
Pending Verification from original state of licens	09/26/2006	09/27/2006	britenour
Pending FBI Prints	09/26/2006		CRISTINA OATES
Temporary Pending	09/26/2006		CRISTINA OATES
Application Deficiency Notice Sent	09/26/2006	06/11/2007	PAULA DELPTHY
Pending Proof of Previous/Current Employment	09/26/2006		CRISTINA OATES
Complaint/Self Report	10/09/2007	04/01/2008	MARY RAPPOPORT
Application Withdrawn	03/25/2008	04/01/2008	MARY RAPPOPORT
Application Initiates Investigation	03/25/2008	04/02/2008	DOLORES HURTADO
Voluntary Surrender - Privilege to Practice	04/02/2008		TRINA SMITH

SCHOOL INFORMATION

NAME	LOCATION	NCLEX CODE	DEGREE OBTAINED	GRADUATION DATE
HOWARD COMMMNITY COLLEGE	COLUMBIA MD		*Associates in Nursing*	*05/01/1998*

OTHER STATES OF LICENSURE/CERTIFICATION

LIC/CERT NO	STATE	LIC/CERT TYPE	STATUS	LIC/CERT DATE	ORIG STATE
0001176358	VA	REGISTERED NURSE	Active: Good Standing	12/31/2006	N
RN1005724	DC		*Inactive*		N
548533	CA		Inactive		N
R139316	MD	REGISTERED NURSE	Inactive		Y

MOST RECENT APPLICATION INFORMATION

Year: 2006

Employment Status:

Type of Nursing Position:

Major Clinical or Teaching Area in Nursing:

Principle Field of Employment:

ARIZONA STATE BOARD OF NURSING
4747 North 7th Street, Suite 200
Phoenix, Arizona 85014-3653
602-889-5150

IN THE MATTER OF THE PRIVLEGE TO PRACTICE NURSING UNDER THE NURSE LICENSURE COMPACT IN THE STATE OF ARIZONA ISSUED TO:	**CONSENT TO VOLUNTARY SURRENDER MULTI-STATE LICENSURE PRIVILEGE IN ARIZONA AND**
NANCY SUE SUMMERS, AKA NANCY SUE SUMMERS-REYES	
RESPONDENT *NURSE LICENSE NO.: RN0001176358* COMMONWEALTH OF VIRGINIA	**CEASE AND DESIST ORDER NO. 0710030**

A complaint charging NANCY SUE SUMMERS, AKA NANCY SUE SUMMERS-REYES, ("Respondent") with violation of the Nurse Practice Act has been received by the Arizona State Board of Nursing ("Board"). In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. §32-1668(D)(5), Respondent voluntarily surrenders her license privilege to practice under any multi-state licensure in the state of Arizona and agrees to cease and desist the practice of nursing in Arizona.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

FINDINGS OF FACT

1. Respondent holds professional nurse licensure, with multi-state licensure privileges ("Privilege") under the Nurse Licensure Compact ("Compact"), issued by The Commonwealth of Virginia, a Compact State.

2. On or about September 13, 2006, Respondent submitted an application for professional nurse licensure by endorsement to the Board.

3. On or about September 26, 2006, Respondent was mailed a deficiency notice regarding her endorsement application. Respondent failed to respond to the application deficiencies. On March 25, 2008, Respondent's application was withdrawn.

COMPLAINT #1

4. From on or about August 27, 2007, to on or about October 1, 2007, Respondent was employed as a professional nurse in the Emergency Department (E.D.) at Mesa General Hospital (MGH), in Mesa, Arizona.

5. On or about October 9, 2007, the Board received a complaint from Teri Keel, RN, CNO, MGH. The complainant alleged that Respondent was assigned to a 12-hour night shift, from on or about September 16, 2007, to on or about September 17, 2007, in the E.D. at MGH . On September 17, 2007, at 4:00 a.m., Respondent removed two Percocet tablets for patient J.C. from the E.D.'s PYXIS machine. A review of J.C.'s medical record reflected that Respondent did not obtain a valid physician order for the medication she removed. Respondent failed to document in J.C.'s record that she administered the medication to the patient.

6. From on or about September 16, 2007, to on or about September 17, 2007, Respondent's co-workers asserted that she intermittently displayed behaviors consistent with impairment on duty, including but not limited to closing her eyes during a conversation, would stop talking in the middle of a sentence and then would suddenly awaken. Respondent would also close her eyes while giving shift report to another nurse. Respondent's behavior resulted in a hospital nurse supervisor requesting that Respondent submit to a for-cause urine drug screen (UDS).

7. Respondent's results from the for-cause UDS on September 20, 2007, revealed that she was positive for Opiates, specifically, Codeine, Morphine, Oxycodone and Oxymorphone. During an interview with MGH Human Resources, Respondent admitted that she was not working to her normal

potential and believed it was due to a combination of a medical condition(s) and her prescriptive medications. Respondent did not have a valid prescription for Codeine. Respondent did have a valid prescription for the other medications.

8. In an interview with Board staff on November 26, 2007, Respondent admitted taking three Tylenol # 3 tablets prescribed to her fiancé.

9. On or about September 27, 2007, Respondent's employment was terminated by MGH and she was notified that a complaint would be filed against her professional nurse licenses with the Commonwealth of Virginia Board of Nursing and the Arizona State Board of Nursing.

10. On or about November 30, 2007, Board staff interviewed Barbara Gribbin, RN, MSN, E.D. Director at MGH. According to Ms. Gribbin, Respondent's co-workers contacted the night shift nurse supervisor after they observed that Respondent had difficulty remaining awake and alert during conversations and would "...stare off into space."

COMPLAINT #2

11. From on or about October 7, 2004, to November 2007, Respondent was employed by American Mobile Nursing, in San Diego, CA, as a travel registry nurse.

12. On or about December 17, 2007, Sally Dimond, RN, CNO at Banner Thunderbird Medical Center (BTMC), submitted a complaint to the Board against Respondent. Respondent was assigned to the Emergency Department at BTMC, in Phoenix, AZ from October 1, 2007 through November 27, 2007.

13. BMTC performed a random audit on twenty Respondent's PYXIS records from on October 1, 2007 through to November 27, 2007. The audit revealed that only two of twenty patient records were in compliance with BMTC's controlled substance documentation policy and procedure. In four out of twenty charts where Respondent removed intravenous Morphine Sulfate (10mg) vials from

HM

the PYXIS, there were no physician orders and Respondent failed to provide documentation in the patient records.

14. Respondent removed a total of 236 mg of intravenous Morphine Sulfate, she documented 130 mg as given in either the medical record or electronic MAR, but did not account for or document a total of 106 mg. Among the unaccounted-for Morphine Sulfate is 20mg withdrawn for a 17 month old patient where there were no doctor's orders. Board staff reviewed the random chart audit and the pertinent patient charts; Board staff's review revealed the documentation errors listed in the attached table of occurrences from October 20 through November 25, 2007.

15. Respondent removed a total of 100 mg of Demerol (Meperidine) for one patient, but did not document the medication as either given in the patient medical record or document the medication as wasted.

16. On or about January 20, 2008, Board staff conducted an interview with BMTC's Emergency Director of Nursing. She stated that Respondent's co-workers had noticed a decline in the quality of her nursing performance and observed her to have increasing lethargy and sleepiness during her assigned shifts. During one shift Respondent's co-workers observed that she had dosed off and subsequently fell out of her chair in the nursing station.

17. Respondent's travel contract with American Mobile Nursing was terminated as a result of these events.

COMPLAINT #3

18. From on or about February 26, 2008, to on or about March 11, 2008, Respondent was employed as a travel nurse with Supplemental Health Care; and assigned to Del E. Webb Hospital (DEWH) in Sun City West, Arizona.

19. On or about March 12, 2008, a complaint was filed with the Board against Respondent by Elizabeth Larken, RN, Director of Critical Care at DEWH. The complaint alleged that Respondent removed seven syringes of Demerol (Meperidine) totaling 350 mg and proceeded to place the Demerol into one large 12cc syringe and went into a staff bathroom. The staff observed that Respondent from the onset of her assigned shift appeared to be "...strange, disorganized and frazzled." Respondent's behaviors resulted in the house nursing supervisor being contacted by charge nurse Vibiana Gonzalez, R.N.

20. On or about March 9, 2008, Ms. Gonzalez and Harriet Moore, RN, House Supervisor questioned Respondent about the removal of Demerol and Lorazepam from the PYXIS. Respondent stated that she administered some of the Demerol and wasted some without a witness, but she could not explain to whom or why she administered the medications Demerol and Lorazepam. Prior to leaving the telemetry unit, Respondent indicated to Ms. Gonzalez that she needed to return one 2mg vial of Lorazepam to the PYXIS. There were no valid physician orders for Respondent to administer either Demerol and/or Lorazepam to any of her assigned patients.

21. On or about March 9, 2008, Ms. Gonzalez observed what appeared to be an abscessed-like area on Respondent's left hand, needle tracks on both hands and wrists; and noticed a fresh bleeding needle-stick on her right wrist.

22. On or about March 9, 2008, Respondent was informed that she was dismissed from her assignment, informed that her employer Supplemental Health Care, would be contacted and then she was asked to leave the hospital.

23. On or about March 9, 2008, after Respondent left the telemetry unit, nursing staff reported that patient medication records, nursing notes, EKG strips and flowsheets were missing for three of Respondent's assigned patients.

24. On or about March 24, 2008, during an interview with Board staff, Ms. Larkin stated that on or about March 9, 2008, Respondent contacted patient F.A.'s physician because of a change in condition. Respondent was given a verbal order to transfer F.A. to the Intensive Care Unit (ICU). Respondent failed to contact the hospital's "rapid response team" in to facilitate the immediate transfer of the patient. Patient F.A. was transferred at 12:40 p.m. to the ICU after Respondent was discharged from her shift.

25. On March 12, 2008, Supplemental Health Care asked Respondent to submit to a for-cause UDS. Respondent complied, and her UDS tested positive for Benzodiazepines, specifically Lorazepam, Opiates, Morphine, Hydromorphone, Meperidine (Demerol), Oxycodone and Oxymorphone, confirmed by GC/MS testing. Respondent did not have valid prescriptions for Demerol or Lorazepam. Respondent did have prescriptions for the other medications. On or about February 14, 2008, February 18, 2008 through February 22, 2008, and February 28, 2008 through March 3, 2008, Respondent was hospitalized. During the hospitalization, Respondent was given multiple IVs during her visits and received Demerol and Lorazepam. Her last dose of Demerol was the day of her discharge on March 3, 2008.

26. From on or about March 11, 2008, Supplemental Health Care suspended Respondent from accepting any scheduled patient care assignments with their agency. Board staff reviewed Respondent's employment application dated December 8, 2007. Under the section entitled "pre-employment" she answered "no" the following question, ""Has your professional license or certification ever been investigated or suspended?" Respondent signed an "employee attestation" that indicated she understood, agreed and acknowledged that the information she provided to her employer was true and complete to the best of her knowledge.

COMPLAINT #4

27. On or about March 10, 2008, Respondent was assigned to the telemetry unit at Boswell Memorial Hospital (BMH), in Sun City, Arizona.

28. On or about March 11, 2008, Supplemental Health Care received a March 10, 2008 evaluation about Respondent work while assigned at BMH. Respondent's work performance including the quality of work, nursing process, and documentation was rated as unsatisfactory and or needs improvement. Written comments from staff nurse stated that Respondent failed to provide a patient with appropriate discharge documentation, even when specifically instructed, failed to document any initial nursing assessment on a newly admitted patient and failed to document a nursing assessment on at least two patients. Staff reported Summers was "...very slow mentally and very slow to respond to questions at times."

29. On or about March 24, 2008, during an interview with Board staff, Reed Beck, manager of the BMH Staffing Office, stated that he learned from telemetry staff that Respondent drew up Morphine Sulfate, placed the syringe into her pocket and went to the bathroom for approximately 10 minutes. Mr. Beck stated that telemetry staff also observed Respondent falling asleep while standing up and removing medications from the PYXIS machine. Mr. Beck stated that the charge nurse requested that a PYXIS report be run by the pharmacist. According to Mr. Beck, Respondent had removed a large amount of controlled substances, the PXYIS report totaled seven to eight pages for Respondent's one day shift on March 10, 2008.

BOARD INVESTIGATION/INTERVIEWS

30. On or about November 26, 2007, Respondent was interviewed by Board staff. During this interview, Respondent disclosed her prescriptive medications that included Naproxen, MS Contin and Oxycodone, which has been prescribed for chronic lower back pain. Respondent admitted taking

her fiancé's Tylenol #3 and believed that this was the reason for her positive UDS submitted on September 20, 2007.

31. On or about March 25, 2008, during a second interview with Board staff, Respondent stated that she suffers from an unknown/unspecified auto-immune condition and in the past three months was hospitalized three times for this condition. Respondent stated that her current prescriptive medications included Plavanil, Prednisone, Lasix, MS Contin and Oxycodone.

32. According to Respondent as a result of her medical condition and prescriptive medication, her memory and cognitive ability has been negatively affected. Respondent described feeling "...like I have dementia..." and that she was "...unsafe, placed patients at risk." Respondent did not dispute that she is responsible for the missing narcotics and asserted that if she signed them out, that she then administered them to a patient.

33. Board staff observed that Respondent's arms and feet had multiple needle marks, bruises in various stages of resolution and recent needle punctures. Respondent attributed the condition of her hands, arms and feet to recent hospitalizations and intravenous injections.

34. From on or about August 22, 2006, until the present time, Respondent has been a patient at The Pain Center of Arizona in Peoria, Arizona. Respondent's primary pain management physician has been John Badalmanenti, M.D.

35. On or about August 9, 2006, Respondent entered into her first contractual education and contract agreement for treatment of opioid (narcotic) pain medication management. The contract stated in part:

a) I certify that I will keep my pain management physician informed of all other medications and procedures/treatments that I am receiving.

b) I certify that I will keep only ONE SOURCE for receiving ALL opioid medications; which includes other physicians, Emergency Room visits, and/or "off the street" sources. I understand that acute conditions may occur that require additional short-term needs for pain control (i.e. dental work, surgery, trauma), and that if this happens, it is acceptable to receive additional opioid medications from the provider caring for me at the time, but I am responsible to inform that provider of my current medication status as well as notifying my pain management physician of the situation.

c) I agree to utilize only ONE pharmacy to which ALL of my opioids (narcotic) prescriptions will be taken or faxed for filling. Pharmacy name/location: Target, Bell and 75th Avenue.

d) I agree to take the opioid (narcotic) medications ONLY as prescribed by my pain management physician, and I agree not to take more than the amount prescribed or take the medications more often than prescribed. I understand that it is a federal offense to alter a prescription in any way.

36. On or about February 16, 2007, The Pain Center of Arizona's office was notified that Respondent had been receiving multiple controlled substances by other licensed health care providers, a direct violation of her August 9, 2006 pain management contract.

37. On or about February 29, 2007, Dr. Badalmanenti, confronted Respondent with her violation of her pain management contract. Respondent stated that she weaned herself off her narcotic medications and threw them away. Respondent admitted that she sought additional pain medications from her PCP's office after being involved in an automobile accident and filled those prescriptions at another pharmacy. Respondent agreed that her actions constituted a violation of her August 9, 2006

pain management contract and signed a second pain management contract with Dr. Badalmanenti on February 29, 2007.

38. On or about March 30, 2008, Respondent requested to voluntarily surrender her privilege to practice nursing in the State of Arizona.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §§ 32-1606, 32-1663, 32-1664, 32-1668 **Article II, III and V**, the Board has subject matter and personal jurisdiction in this matter.

The conduct and circumstances described in the Findings of Fact constitute a violation of A.R.S. § 32-1601(16)(d), (e), (g), (h), and (j), and A.A.C. R4-19-403(B), (1), (7), (8)(a),(b), (9), (17), (18), (26), (27), and (31). (Adopted and effective July 19, 1995).

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§ 32-1663 (D)(5) 32-1664(N) to take disciplinary action against Respondent's privilege to practice as a professional nurse in the State of Arizona.

Respondent admits the Board's Findings of Fact, Conclusions of Law.

Respondent understands that she has an opportunity to request a hearing and declines to do so. Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this voluntary surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. Respondent's signature obtained via facsimile shall have the same effect as an original signature. Once signed by the Respondent, the agreement cannot be withdrawn without the Executive Director or the Board's approval or by stipulation between the Respondent and the Executive Director or the Board. The effective date of this Order is the date the Voluntary Surrender is signed by the Executive Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the later date is the effective date.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that she may not reapply for reinstatement during the period of Voluntary Surrender.

Respondent agrees that she may apply for reinstatement after the period of voluntary surrender under the following conditions, and must comply with current law at the time of their application for reinstatement:

The application for reinstatement must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and that the reinstatement of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding the Respondent as it deems necessary. These conditions shall be met before the application for reinstatement is considered.

Nancy S. Summers

Nancy S. Summers, Respondent

Date: 4/1/08

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 4/2/08

RAPPOPORT:VAR\00011769\8\SUMMERS N

ORDER

Pursuant to A.R.S. § 32-1663(D)(5) the Board hereby accepts the Voluntary Surrender the privilege to practice nursing in Arizona under the multi-state license number RN0001176358 issued by The Commonwealth of Virginia. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multi-state license issued by any other state.

IT IS FURTHER ORDERED that Respondent may apply for reinstatement of said privilege after a period of three (3) years.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour RN MN FAAN

Joey Ridenour, R.N., M.N., F.A.A.N.
Executive Director

Dated: 4/2/08

HH

JR/mer

COPY sent via electronic email this 30th day of March, 2008, to: kelly@bivenslaw.com
and sent via facsimile to: 480-907-3323

Kelly J. McDonald, J.D., RN
Legal Counsel for Nancy Sue Summers
5020 E. Shea Boulevard, Suite 210
Scottsdale, AZ 85254

Nancy Sue Summers
10940 West Morten Avenue
Glendale, AZ 85307

By: Mary E. Rapoport, RN, MN
Mary E. Rappoport, RN, MN
Nurse Practice Consultant

Occurrence Date	Medical Record # (MRN)	Physician Order (Y or N)	Medication(s) removed by Summers	Summers documentation
10/20/07	MRN821728	Y	2 Percocet tablets @ 0149	"NS" initialed @ 0145, not documented in e-MAR
10/21/07	MRN752301	Y	(1 vial) 10mg MSO4 @ 2052 (1 vial) 4mg MSO4 @ 2155	2 mg IVP @ 2102 in ER record. **12 mg not documented as wasted or given**
10/30/07	MRN249067	Y	(1 vial) 4 mg MSO4 @ 1841 (1 vials) 10 mg MSO4	4 mg IVP given @ 1850. 4mg IVP given at 2100 & 2200. **12 mg not documented as wasted or given**
11/05/07	MRN745930	Y	(1 vial) 4 mg MSO4 @ 0303 (1 vial) 10 mg MSO4 @ 0501	2 mg IVP given @ 0306 2 mg IVP given @ 0418 4 mg IVP given @ 0457 in the electronic MAR 6 mg **not documented as wasted or given**
11/06/07	MRN898693 (17 month patient)	N	(1 vials) 10 mg MSO4 @ 1858 & 1859	**No documentation**
11/06/07	MRN850679	Y Y Y Y	2 tablets Vicodin @ 2215 (1 vials) 1mg Dilaudid @ 1916 & 1959 (1 vials) 10 mg MSO4 @ 2215 & 2249 2 Percocet tablets @ 2215	2 tabs given @ 2214 1 mg given @ 1930 by "NS" 1 mg given @ 2100 by another RN 4 mg given @ 2215 in electronic MAR. **10 mg not documented as wasted or given** **No documentation as given in ER record or e-MAR**
11/06/07	MRN590294	Y	(1 vial) Dilaudid @ 2112 (1 vial) 4mg MSO4 @ 2112	** Meds pulled by Summers, given by another nurse
11/13/07	MRN640947	Y	(1 vial) 10 mg MSO4 @ 1349 & 1431	2 mg given @ 1401 (e-MAR) 4 mg given @ 1430 (3-MAR) **14 mg not documented as given or wasted**
11/13/07	MRN318938	Y	(1 vial) 10 mg MSO4 @1647 & 1758	4 mg given @ 1645 **16 mg not documented as given or wasted**
11/14/07	MRN735161	N	(1 vial) 10 mg MSO4 @ 1819	**Pt. not admitted to ER; but oncology pt. w/recurring order; blood draws only**

11/14/07	MRN931443	Y	(1 vial) 100 mg Demerol @ 1743 (1 vial) 10mg MSO4 @ 1614	**No documentation.** 4 mg given @ 1616, no **documentation 6mg wasted or given**
Occurrence Date	**Medical Record #(MRN)**	**Physician Order (Y or N)**	**Medication(s) removed by Summers**	**Summers documentation**
11/14/07	MRN931443	Y	(1 vial) Dilaudid @ 1705	Given @ 1700 on ER record
11/14/07	MRN734662	N	(1 vial) 10mg MSO4 @ 0837	**Pt. was not admitted on this date, No orders**
11/15/07	MRN951543	N	(1 vial) 10 mg MSO4 @ 1305	**This is an OB pt. & was sent to OB triage area from ER**
11/15/07	MRN953745	N	(1 vial) 10 mg MSO4 @ 0918	**No order, pt. triaged out of ER @ 0926**
11/19/07	MRN932514	Y	(1 vial) 10 mg MSO4 @ 1328	4 mg given @ 1515; 6 mg documented as wasted
11/19/07	MRN917892	Y	(2 vials) 10 mg MSO4 @ 1145	**Summers pulled medication, but was given by another RN; no waste/documentation by either nurse**
11/25/07	MRN554872	Y	(1 vial) 10mg MSO4 @ 1000	4mg given @ 1005; no **documentation 6mg wasted or given**
11/25/07	MRN705050	Y	2 Vicodin tabs @ 1352 (1 vial) 10 mg MSO4 @ 1125 & 1351	Documented in E-MAR as given 6 mg Documented in E-Mar as given @ 1125 & 1350; 4 mg waste documented.